

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 232

CERTIFICATE OF DEATH

64479

21

Reg. Dist. No.

1. PLACE OF DEATH:

Anne Arundel County

County

Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

2 months, 11 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

2 months, 11 days

How long in hospital or institution?

3. (a) FULL NAME

ARMSTRONG - MOLLIE

4. Sex

female

5. Color or race

black

6.(a) Single, married, widowed, or divorced

widow

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1895 ?

8. AGE:

51 ?

Years

Months

Days

if less than one day

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Isaac Sample

MOTHER FATHER

12. Name

Isaac Sample

13. Birthplace

Virginia

14. Maiden name

Margaret Dorsey

15. Birthplace

Maryland

16. Informant

Hospital Records

Address

Crownsville, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

New Cathedral
Baltimore City, Maryland

Location

18. Funeral director

Mrs. Gertrude Holland

Address

1833 Druid Hill Ave.

19. Date rec'd by registrar

5/17/46

19. 46

Anne Armstrong

Signature

Registrars

Signature

M. D. or other

Signature

Date signed

5/15/46

Signature

Address

Crownsville, Maryland

Date signed

5/15/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1833 Druid Hill Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 15

1946

at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 1946 to May 15 1946,

and that I last saw her alive on May 15 1946.

Immediate cause of death

Hypertensive Cardiovascular Disease

Due to

Due to

Other conditions

Senile Psychosis

Known to us since

3/4/46

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

M. D. or other

Address

Crownsville, Maryland

Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

64480

CERTIFICATE OF DEATH

21



Reg. Dist. No....

1. PLACE OF DEATH:

County

Anne Arundel

City or town

W. Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4 Murray Street

How long in hospital or institution?

3. (a) FULL NAME

Alice Elizabeth

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white Married

6.(b) Name of husband or wife

George C. Bailey

7. Birth date of deceased (mo., day, yr.)

May 12th 1906

6.(c) If alive, give age years

8. AGE:

Years Months Days If less than one day
40 0 4 hrs. min.

9. Birthplace

Pennsylvania

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

—

12. Name

James P. Bailes

13. Birthplace

Pennsylvania

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

George C. Bailey

Address

W. Annapolis, Md.

17. Burial

Date thereof May 30th 1946
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Cedar Bluff Cemetery

Location

Annapolis, Maryland

18. Funeral director

John W. Taylor & Son

Address

Annapolis, Md.

19. May 20 46
(Date rec'd by registrar)

J. D. - O. D. - S. S. - W.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

City or town

W. Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.

4 Murray St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

Bailey

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 16 1946 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 3 1946 to May 16 1946

and that I last saw him alive on May 15 1946

Immediate cause of death

Pulmonary Tuberculosis 6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

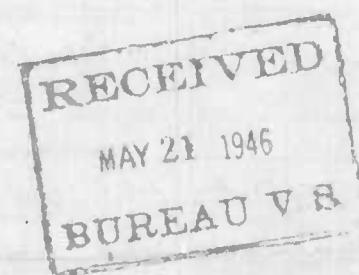
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE

M. J. Klawans, M.D. or other

Address 31 Southgate Ln. Date signed 5/17/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 21201

04481

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Jewel, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles W. Bias

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

C

Single

B.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years Months Days If less than one day
61 hrs. min.9. Birthplace Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name John Bias

13. Birthplace Md

MOTHER 14. Maiden name Susie Stokes

15. Birthplace Md

16. Informant Savannah Reid

Address Jewel, Md.

17. Burial Date thereof 5 21 46
(Burial, cremation, or removal. Which?)

Cemetery or crematory Carter's Chapel

Location Friendship, Md

18. Funeral director P.C. Scovell

Address Prince Frederick, Md.

19. May 20 1946 H.W. Ward
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Anne Arundel

City or town Jewel
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17-1946, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to May 17 1946, and that I last saw him alive on

Immediate cause of death Hypertension & heart disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

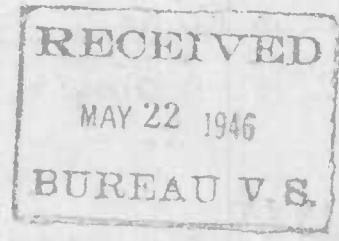
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. W. Ward

M. D. or other

Address Humphrey Ward Date signed 20 May 46



Evidence for the change
of age of deceased is shown
or

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 2D

P
04482

FILM No. I 04 JUN - 6 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County
City or town
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Katherine Elizabeth Billingslea.

3. (b) Social Security Number

None

4. Sex F. 5. Color or race W. Married.

6. (a) Single, married, widowed, or divorced
Dr. James S. Billingslea.6. (c) If alive, give age 61 years
7. Birth date of deceased (mo., day, yr.) 6/14/82

8. AGE: Years 63 Months 6/11 Days 7 If less than one day hrs. min.

9. Birthplace Cambridge, Md.
(Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business Element Bell

12. Name Dr. James S. Billingslea.

13. Birthplace Cambridge, Md.

14. Maiden name Unknown.

15. Birthplace Cambridge, Md.

16. Informant Dr. James S. Billingslea.

Address Elbow Burnie, Md.

17. Burial Date thereof 5/24/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. Date rec'd by registrar 5/22/46 A.W. Hedrick

Registrar DM.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County D. A.

City or town Elbow Burnie.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 114 - Central Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 21st 1946 at 8³⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h. alive on..... 19.....

Immediate cause of death.....

Cerebral Hemorrhage 10 days

Due to.....

Cardiovascular disease 10 years

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

A. W. Hedrick M. D. or other

Address Elbow Burnie, Md. Date signed 5/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47D

04483

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Anne Arundel
 County.....
 City or town..... Green Haven, Pasadena, Md. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Years
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 State..... Maryland County..... Anne Arundel
 City or town..... Green Haven, Pasadena, R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
 Street No..... Fourth & Mayford Aves.
(If rural, give LOCATION)
 2.(a) If veteran, name war.....

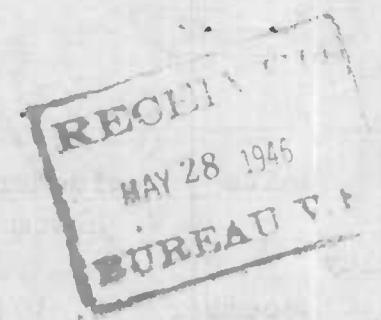
3. (a) FULL NAME SAMUEL E. BLOOM

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		
Male	White	Widower		
B.(b) Name of husband or wife Ida V. Bloom				
Nee Lamley				
B.(c) If alive, give age X years				
7. Birth date of deceased (mo., day, yr.) December 9, 1946 1870				
8. AGE:	Years	Months	Days	If less than one day
	75	4	28	hrs. min.
9. Birthplace Howard Co. Md.				
(Town, county, and state)				
10. Usual occupation Retired Tavern Keeper				
11. Industry or business Own Business				
MOTHER FATHER	12. Name Henry Bloom			
	13. Birthplace Germany			
MOTHER	14. Maiden name Rachel - Unknown			
	15. Birthplace Unknown			
16. Informant Earl S. Bloom				
Address Green Haven, Pasadena, Md. R.F.				
17. Burial Date thereof May 24, 1946				
(Burial, cremation, or removal. Which?) (month) (day) (year)				
Cemetery or crematory New Cathedral				
Location Baltimore, Md.				
18. Funeral director Thomas W. Dugdale				
Address Glen Burnie, Md.				
19. (Date rec'd by registrar) 5/27 1946 Registrar				

3. (b) Social Security Number NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH	May	21	19	46	ai	9.40A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from						
12/4/46 1945 to 5/21 1946						
and that I last saw him alive on 5/21/46						
Immediate cause of death Pulmonary Hemorrhage						
DURATION						
Due to:						
Due to:						
Other conditions Gastroenteritis						
(Include pregnancy within 3 months of death)						
Major findings of operations						
Date of op.						
Autopsy results						
PHYSICIAN: Please underline the cause to which death should be charged statistically.						
D.						
22. VIOLENCE: If death was due to external causes, fill in the following:						
Accident, suicide, or homicide Date of						
Where did injury occur? (City or town) (County) (State)						
Injured at home, farm, industry, public place (where?)						
Means of injury Injured at work?						
23. SIGNATURE						
Signature L. Granter M.D. or other						
Address 1123 St. Paul St Balto, Md.						
Date signed						



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1948

CERTIFICATE OF DEATH

04484

Reg. Diat. No. 21

1. PLACE OF DEATH:

County..... Anne Arundel Co.

City or town..... Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 39 years

Hospital, institution, or street address where death occurred:

20 College Ave.

How long in hospital or institution?..... None

3. (a) FULL NAME

Margeret Fields Brooks

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

Female..... Col. Married

6. (b) Name of husband or wife..... William Brooks

6. (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) October 2, 1906

8. AGE: Years Months Days If less than one day
39 hrs. min.9. Birthplace..... Annapolis Md. A. A. Co.
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... None

12. Name..... Joseph Fields

13. Birthplace..... New York N. Y.

14. Maiden name..... Ethel Davage

15. Birthplace..... Annapolis Md.

16. Informant..... Wm. Brooks Sr.

Address..... 20 College Ave. Annapolis Md.

17. Burial..... Date thereof..... 5/4/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Saint Marys Cemetery

Location..... West St. extd.

18. Funeral director..... Mrs. Charles E. Hicks

Address..... 45 Northwest St. Annapolis Md.

19. May 2 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 20 Colleges Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war..... None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 1 1946 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
2-8 1946 to 5-1 1946

and that I last saw her alive on 4-10-46 1946

Immediate cause of death..... congested heart failure

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

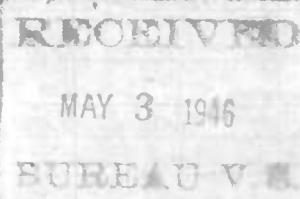
Means of injury.....

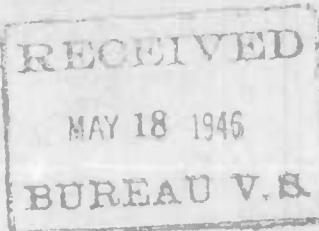
Injured at work?

23. SIGNATURE..... A. T. Clegg

M. D. or other

Address..... 17 Carroll St. Date signed..... 5-2-46





D.P.
Johnson

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

04486

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County.....

City or town.....

Anne Arundel
Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth Bundy

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female colored

widow

8. (b) Name of husband or wife

Wm. Bundy

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years
1867

8. AGE:

Years

Months

Days

If less than one day

79

.hrs.

.min.

9. Birthplace

Anne Arundel Co.
(Town, county, and state)

10. Usual occupation

Seamstress

11. Industry or business

12. Name

Wm. Freeland

13. Birthplace

Calvert Co.

14. Maiden name

Eliza Booze

15. Birthplace

Md

16. Informant

Address

Lloyd Bundy
38 Lafayette St Annapolis

17. (Burial, cremation, or removal. Which?)

Date thereof

May 21 1946
(Month) (day) (year)

Cemetery or crematory

Mt. Auburn

Location

Baltimore, Md.

18. Funeral director

J.B. Johnson

Address

Annapolis, Md.

19. (Date rec'd by registrar)

May 21 1946

D.O. French

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County..... Anne Arundel

City or town.....

Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No.

38 Lafayette Ave. (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 17, 1946, et 11:57 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 16 1946, to May 17 1946

end that I last saw her alive on May 17 1946

Immediate cause of death Apoplexy

Due to Hypertension

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, term, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....

Hedie J. Johnson, M.D. M. D. or other

Address..... 40 Northwest Blvd. Date signed 5/20/46

RECEIVED

MAY 22 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93D

04487

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County BaltimoreCity or town Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

22 years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Margaret Bussey

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

Widow

6. (b) Name of husband or wife

William F. Bussey

7. Birth date of deceased (mo., day, yr.)

January 3, 1886

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Posen

Germany

(Town, county, and state)

10. Usual occupation

House Work

11. Industry or business

Own Home

MOTHER FATHER

12. Name August Tepper

13. Birthplace

Germany

14. Maiden name

Augusta Knopp

15. Birthplace

Germany

16. Informant

Mrs. Frederick Aschmeyer

Glen Burnie, Md.

Address

17. Burial

Date thereof May 25, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Cedar Hill

Location

Cedar Hill, Brooklyn, Md. R.F.

18. Funeral director

Thomas W. Singleton

Address

Glen Burnie, Md.

19. Date rec'd by registrar

1946

5/24

J. McGehee

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Anne Arundel

City or town

Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Crain Highway

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1946, at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945, to May 21, 1946

and that I last saw her alive on May 21, 1946

Immediate cause of death

Cardio-Vascular Disease

DURATION

8 yrs

Due to

Due to

Other conditions Griggs & Bronchitis, 1 week

INCLUDE PREGNANCY WITHIN 8 MONTHS OF DEATH

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

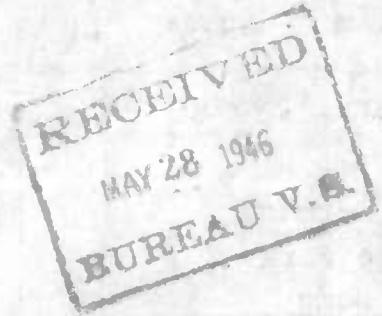
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Chas. L. Ball Jr. M. D. or otherAddress Glen Burnie Date signed 5-21-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

04488

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH:
Anne Arundel County
County.....

City or town..... Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 6 yrs, 11 mos, 14 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 6 yrs, 11 mos, 14 days

3. (a) FULL NAME

CASHWELL - DAVID

4. Sex male	5. Color or race black	6.(a) Single, married, widowed, or divorced married
----------------	---------------------------	--

6.(b) Name of husband or wife..... Gladys Cashwell, 446 High
St., Balto., Md. (?)
6.(c) If alive, give age..... years

7. Birth date of
deceased (mo., day, yr.) 1913 ?

8. AGE: Years 33 ?	Months unknown	Days -----	If less than one day ----- hrs. ----- min.
-----------------------	-------------------	---------------	---

9. Birthplace..... Virginia
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business.....

12. Name..... Ben Cashwell

13. Birthplace..... Virginia

MOTHER FATHER
14. Maiden name..... Mattie Sparrow

15. Birthplace..... Virginia

16. Informant..... Hospital Records

Address..... Crownsville, Maryland

17. Burial Date thereof..... 5/14-46
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Hospital

Location..... Crownsville

18. Funeral director..... Soft

Address..... Crownsville

19. (Date received by registrar) May 14 1946

20. (Date registered) 27 JUN 1946

Registrar..... E. John Rose

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore City (?)
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 446 High Street (?)
(If rural, give LOCATION)

2.(a) If veteran, name war..... unknown

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 3 1946 at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 19 1939 to May 3 1946

and that I last saw h...im....alive on May 3 1946

Immediate cause of death..... Lung Tuberculosis Known to us since 3/12/46

DURATION

Due to.....

Due to.....

Other conditions..... Paranoid Condition Known to us since 5/19/39

(Include pregnancy within 3 months of death)

Major findings or operations..... Date of op.....

Autopsy results..... Lung tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

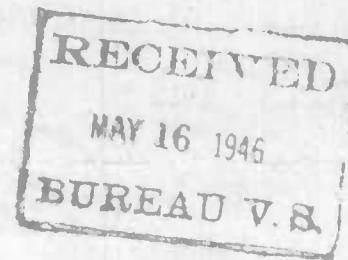
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Crownsville, Maryland Date signed 5/3/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1170

04489

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel
 County: Annapolis, Md.
 City or town: Annapolis, Md. (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? IV 36 hours.
 Hospital, institution, or street address where death occurred: Emergency Hospital
 How long in hospital or institution?

3. (a) FULL NAME

4. Sex: <u>Male</u>	5. Color or race: <u>white</u>	6. (a) Single, married, widowed, or divorced: <u>Married</u>		
6. (b) Name of husband or wife: <u>Magda L. Chamberlain</u>		6. (c) If alive, give age: <u>49</u> years		
7. Birth date of deceased (mo., day, yr.): <u>September 21, 1882</u>				
8. AGE:	Years: <u>62</u>	Months: <u>1</u>	Days: <u>2</u>	If less than one day hrs.: min.:

9. Birthplace: Terra Haute Ind.
 (Town, county, and state)
 10. Usual occupation: Editor Public Relations (Retired)
 11. Industry or business: Amcy. Hammer & Piston Ring Co.
 12. Name: Kelly Monroe TURNEY
 13. Birthplace: UNKNOWN
 14. Maiden name: Carrie Chamberlain
 15. Birthplace: Milleville Md. Lima Peru
 16. Informant: Mrs. P. E. Chamberlain

Address: Milleville, Md. R.F.D.
 17. Cremation: Cremation Date thereof: May 4, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory: Loudon Park
 Location: Baltimore, Md.
 18. Funeral director: Thomas W. Swanson
 Address: Hew Burnie, Md.
 19. Date rec'd by registrar: May 21 1946 Registrar: Medallia
 (Date received by registrar) (Name of registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Anne Arundel
 City or town: Milleville R.F.D. (If outside city or town limits, write RURAL and give nearest town)
 Street No.: Indian Landing Road. (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) Social Security Number: (Adopted) 212-09-8440

MEDICAL CERTIFICATION

2D. DATE OF DEATH: 5-1-46

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-29-46 to 5-1-46, and that I last saw him alive on 5-1-46.

Immediate cause of death:

Gastric Hemorrhage

DURATION

5 day

Due to:

Gastric ulcer3 yrs

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

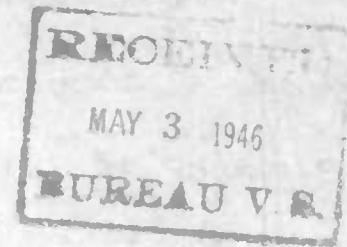
Means of injury

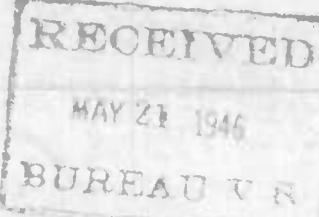
Injured at work?

23. SIGNATURE: Percival Edward Chamberlain

M. D. or other

Address: Annapolis Md. Date signed: 5-1-46





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

04491

Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Anne Arundel
 City or town..... Round Bay, Annapolis Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 1/2 hours
 Hospital, Institution, or street address where death occurred:
 Severn River Round Bay

How long in hospital or institution?

3. (a) FULL NAME

Don Arthur Baum

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 18 - 1930 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
16 13 hrs. min.

9. Birthplace 1000 S. 1st Ohio
(Town, county, and state)

10. Usual occupation School Boy

11. Industry or business

MOTHER FATHER 12. Name Allen W. Baum

13. Birthplace Amherst Ohio

14. Maiden name Evelyn Van Oster

15. Birthplace Elyria Ohio

16. Informant Allen W. Baum

Address Arnoldo Mayfield

17. Cremation Date thereof June 3/46
(Burial, cremation, or removal. Which?)

Cemetery or crematory Fort Lincoln

Location Bladensburg Road

18. Funeral director B. L. Hopkins

Address Annapolis, Md.

19. June 3 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 31 1946 11 5 P.M.

21. I CERTIFY that death occurred on the date above stated: Postmortem Examination

Autopsy results May 31 1946

Immediate cause of death

Drowning

Due to

Accidental

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5/31/46

Where did injury occur? Annapolis Park, A. A. Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Round Bay

Means of Injury drowning Injured at work? No

23. SIGNATURE John M. Coffey M.D. Deputy medical Examiner

M. D. or other Medical Examiner

Address Annapolis, Md. Date signed 6/1/46

RECEIVED

JUN 4 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4A

CERTIFICATE OF DEATH

04492
Reg. Dist. No. 30

1. PLACE OF DEATH: Anne Arundel
 County: Edgewater
 City or town: Edgewater (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 months
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Anne Arundel
 City or town: Edgewater (If outside city or town limits, write RURAL and give nearest town)
 Street No.: Central Ave (If rural, give LOCATION)

3. (a) FULL NAME Clayborn B. Cox
 4. Sex: Male 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Married
 6. (b) Name of husband or wife: Pauline A. Cox
 7. Birth date of deceased (mo., day, yr.): May 25, 1901 8. (c) If alive, give age: 45 years
 8. AGE: 45 Years 0 Months 1 Days If less than one day: hrs. min.
 9. Birthplace: Princeton West Virginia (City, county, and state)
 10. Usual occupation: Tucker cutter
 11. Industry or business: Lumber business
 MOTHER FATHER 12. Name: William H. Cox
 13. Birthplace: West Virginia
 14. Maiden name: Emma Beckman
 15. Birthplace: West Virginia
 16. Informant: Mrs. Pauline A. Cox
 Address: Edgewater P.O. Md
 17. Buried: Buried Date thereof: May 29/46
 (Burial, cremation, or removal, When) (month) (day) (year)
 Cemetery or crematory: Trinity M.E.
 Location: Woodstockville Rd
 18. Funeral director: B-L Hopkins
 Address: Annapolis Md
 19. Date rec'd by registrar: May 28 1946 Registrar: Edward Collier

3. (b) Social Security Number: 227-05-7967

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1946 11²⁰ AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Potomac Examination and that last saw him alive on May 27 1946.
 Immediate cause of death: Coronary embolism sudden
 Due to: Coronary sclerosis unknown
 Other conditions:

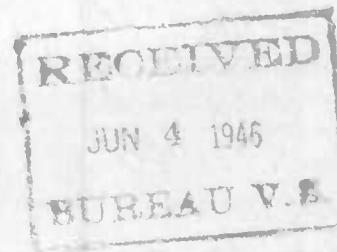
DURATION

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide: Date of:
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?):
 Means of injury: Injured at work:
 23. SIGNATURE: John M. Coffey M.D. M.D. or other: Deputy Medical Examiner
 Address: Annapolis, Md. Date signed: 5/27/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P

04493 23
Reg. Dist. No.

1. PLACE OF DEATH:
 County..... Anne Arundel
 City or town..... Brooklyn
 (If outside city or town limits, write RURAL and give nearest town)
 Now long in above place of death?..... 50 years
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Anne Arundel
 City or town..... Briiklyn
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 4500 Ritvhie Highway
 (If rural, give LOCATION)

3. (a) FULL NAME

LEONHARDT EBERSBERGER

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married
6.(b) Name of husband or wife..... Louise Ebersberger		

7. Birth date of deceased (mo., day, yr.)..... March 1, 1885
 8. (c) If alive, give age..... years

8. AGE:	Years	Months	Days	It less than one day
	61	2	13	hrs. min.

9. Birthplace..... Germany
 (Town, county, and state)

10. Usual occupation..... Grocer

11. Industry or business

12. Name	Michael Ebersberger
13. Birthplace	Germany

14. Maiden name	Helena Schafer
15. Birthplace	Germany

16. Informant..... Leonhardt Ebersberger
 Address..... 457 W. Meadow Road

17. Burial..... May 17, 1946
 (Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)
 Cemetery or crematory..... Cedar Hill

Location..... Anne Arundel Co.
 18. Funeral director..... Ullrich Funeral Home

Address..... 2008 Orleans St.,
 19. 5-16-46 *John G. Schaeffer*
 (Date rec'd by registrar)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 13 46 at 11 p.m.

21. I CERTIFY that death occurred on the date above stated; *I attended deceased from*
May 1 46 to May 13 46
 and that I last saw h. s. alive on *May 13 46*
 Immediate cause of death..... *Cerebral Thrombosis*

DURATION

Due to.....

Due to.....

Other conditions..... *arteriosclerosis*
hypertension, hypertension
 (Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. _____

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?) _____

Means of injury.....

Injured at work? _____

23. SIGNATURE..... *John G. Schaeffer*

M. D. or other _____

Address..... 337 S. Charles St., Date signed..... 5/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

04494

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel Co.
County.....

City or town..... Annapolis Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:

45 Larkins St. Annapolis Md.

How long in hospital or institution? *****

3. (a) Deceased's NAME

Emma Luretta Edwards

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) June 10, 1876

8. AGE: Years	Months	Days	If less than one day
69	11		hrs. min.

9. Birthplace..... Green Castel Penn. (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... None

12. Name..... Charles Wesley Campbell

MOTHER FATHER 13. Birthplace..... Warren County Va.

14. Maiden name..... Sally Frances Botts

MOTHER FATHER 15. Birthplace..... Culpepper Virginia

16. Informant..... Mrs Annie Johnson

Address..... 45 Larkins St. Annapolis Md.

17. Burial..... 5/ 26/46
(Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)

Cemetery or crematory..... Mt. Auburn Cemetery

Location..... Baltimore Md.

18. Funeral director..... Mrs Charles E. Hicks

Address..... 45 Northwest St. Annapolis Md.

19. May 25, 46 (Date rec'd by registrar) J. D. French

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel C.

City or town..... Annapolis Md. (If outside city or town limits, write RURAL and give nearest town)

Street No..... 45 Larkins St. (If rural, give LOCATION)

2.(a) If veteran, name war..... *****

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23, 1946 at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 16, 1946 to May 23, 1946, and that I last saw her alive on May 23, 1946.

Immediate cause of death.....

Lobar pneumonia 1 Day

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

M. D. or other

Address..... Annapolis Md. Date signed 5/25/56

LETTER TO THOMAS G. STACEY, CHIEF

DEPARTMENT OF THE AIR FORCE

LETTER TO STADLER, W.C.

LETTER TO LEMMON, C. H. (C. H. L.)

RECEIVED

MAY 28 1948

BUREAU V.E.

M. Richardson ✓

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

04495

28

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Anne Arundel

City or town.....

Waterbury Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ila Edwards

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

Colored

Married

6.(b) Name of husband or wife.....

Beside Edwards

8.(c) If alive, give age..... 75 years

7. Birth date of deceased (mo., day, yr.)

March 26, 1884

8. AGE:

Years
62

Months
10

Days
11

If less than one day
hrs. min.

9. Birthplace.....

A.A. Co. Md

(Town, county, and state)

10. Usual occupation.....

Domestic

11. Industry or business

FATHER

12. Name.....

Jamie Grossery

13. Birthplace

Md.

MOTHER

14. Maiden name.....

Mary (Unknown)

15. Birthplace

Md.

16. Informant.....

Basil Edwards

Address

Waterbury Md

17. (Burial, cremation, or removal, if any?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory

John Wesley

Location

Waterbury Md.

18. Funeral director

J.B. Johnson

Address

Minneapolis Md

19. (Date rec'd by registrar)

May 18 1946

Ed Joyce House

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Maryland Anne Arundel

City or town.....

Waterbury Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 15

1946 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *April 15* to *May 15, 1946*, and that I last saw her alive on *May 15, 1946*.

Immediate cause of death

Cariousia of left breast

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R.H. Johnson Jr.

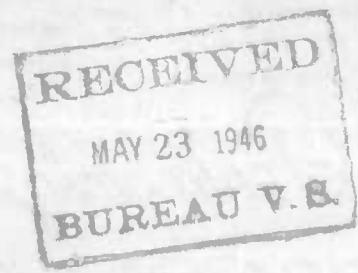
M. D. or other

Address

Newport Md.

Date signed

5/17/46



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4(B)

CERTIFICATE OF DEATH

044258.

Reg. Dist. No.

1. PLACE OF DEATH:

Anne Arundel County

County.....

Crownsville, Maryland

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 2 mos., 7 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 2 yrs., 2 mos., 7 days

3. (a) FULL NAME

EDWARDS - MINNIE

4. Sex
female5. Color or race
black6.(a) Single, married, widowed, or divorced
widow

6.(b) Name of husband or wife.....

6.(c) If alive, give age years

7. Birth date of
deceased (mo., day, yr.) 1904 ?8. AGE: Years
42 ? Months
unknown Days
If less than one day
--- hrs. --- min.9. Birthplace.....
(Town, county, and state)
Virginia10. Usual occupation.....
Housework

11. Industry or business

12. Name..... John Chavis

13. Birthplace..... Virginia

14. Maiden name..... Haddy Ward

15. Birthplace..... Virginia

16. Informant.....
Hospital Records

Address..... Crownsville, Maryland

17. Burial Date thereof..... 3/25/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... Hospital
Crownsville Md
Dept.

18. Funeral director.....

Address..... Crownsville

19. Date rec'd by registrar..... May 24 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Worcester

City or town..... Berlin (If outside city or town limits, write RURAL and give nearest town)

Street No..... unknown

(If rural, give LOCATION) ✓

2.(a) If veteran, name war.....

3. (b) Social Security Number
unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 9

19. 46 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 2 19. 46 to May 9 19. 46
and that I last saw her alive on May 9 19. 46

Immediate cause of death.....

General Paresis

DURATION

Known to us since
3/2/44

Due to.....

Due to.....

Other conditions..... Carcinoma of Uterus

Known to us since
3/2/44

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

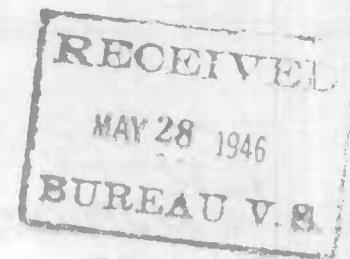
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Crownsville, Maryland Date signed..... 5/9/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B.M.*

CERTIFICATE OF DEATH

04497

Reg. Dist. No. 21

1. PLACE OF DEATH:

County *Anne Arundel*City or town *Eastport*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *37 years*Hospital, institution, or street address where death occurred: *501 - 7th St Eastport*

How long in hospital or Institution?

3. (a) FULL NAME

*Mary Evelyn Fowler*4. Sex *F*5. Color or race *W*6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *Feb 19 - 1893*

6. (c) If alive, give age years

8. AGE:

Years *53*Months *3*Days *9*If less than one day
hrs. min.9. Birthplace *Baltimore*

(Town, county, and state)

10. Usual occupation *House Work*

11. Industry or business

MOTHER FATHER

12. Name *Joseph C. Fowler*13. Birthplace *Calvert Co*

MOTHER

14. Maiden name *Mary Eliza Stevens*15. Birthplace *Calvert Co*16. Informant *Lerry Fowler*Address *Eastport Maryland*

17. Burial

(Burial, cremation, or removal, if applicable)

Date thereof *May 31/46*

(Month) (day) (year)

Cemetery or crematory *Bedford Hill*Location *Near Woods - and -*18. Funeral director *A. L. Hopper*Address *Annapolis Md*

19. May 31

(Date received by registrar)

1946

- D. March

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Anne Arundel*City or town *Eastport*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *501 - 7th St*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH *May 28* 1946 at *8:30 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Dec 19 45* to *May 28 1946*end that I last saw her alive on *May 28 1946*Immediate cause of death *Cerebral Thrombosis*Due to *Hypertensive C.V.R.*
desire

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

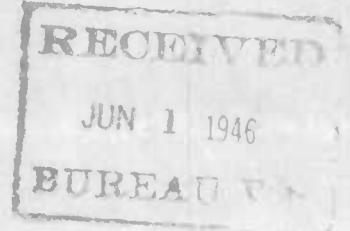
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *E. L. Hopper*M. D. or other *Surgeon, M.D.*Address Date signed *5/30/46*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5

04498

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County.....

Anne Arundel

City or town.....

Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Washington Freeman

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

6. (b) Name of husband or wife

Louise Freeman

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 4, 1874

8. AGE:

Years

Months

Days

11 less than one day

hrs. min.

9. Birthplace

Anne Arundel Co., Md.

(Town, county, and state)

10. Usual occupation

Freeman

11. Industry or business

MOTHER FATHER

George Freeman

A.A. Co., Md.

Josephine Freeman

A.A. Co., Md.

16. Informant

Mrs. Louise Freeman

Address 908 Creek Dr., Eastport, Md.

17. Burial

Date thereof May 28, 1946

(Burial, cremation, or removal, if any)

Cemetery or crematory Cedar Bluff

Location Annapolis, Md.

18. Funeral director

Jeney & Caylor & Son

Address Annapolis, Md.

19. Date rec'd by registrar

May 27, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Anne Arundel

City or town Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 908 Creek Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1946 at

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1, 1944, to May 25, 1946,

and that I last saw him alive on May 24, 1946.

Immediate cause of death Myocarditis, fibrosis

DURATION

2 mo

Due to Cancer of Prostate 2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. Russell M. D. or other

Address Eastport Date signed 5-26-46

RECEIVED

MAY 28 1946

BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

04499

21

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Henry Emil Gertz

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced
Married

6.(b) Name of husband or wife *Amelia Anna Gertz.*
Nee Abend

7. Birth date of deceased (mo., day, yr.) *April 16, 1872*

8. AGE: 77 Years Months Days If less than one day
1 14 hrs. min.

9. Birthplace *Russia*
 (Town, county, and state)

10. Usual occupation *Farmer (Retired)*

11. Industry or business *OWN Farm.*

12. Name *Christian Gertz.*

13. Birthplace *UNKNOWN*

14. Maiden name *Elizabeth Schmidt.*

15. Birthplace *UNKNOWN*

16. Informant *Mr. Gertz.*

Address *Crownsville Md*

17. Burial *Burial* Date thereof *June 1, 1946*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Cedar Hill*

Location *Cedar Hill, Brooklyn Md*

18. Funeral director *Thomas W. Dugoton*

Address *Glen Burnie, Md.*

19. Date rec'd by registrar *June 1, 1946*

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State.....
 County.....
Maryland Anne Arundel

City or town.....
 (If outside city or town limits, write RURAL and give nearest town)

Street No. *Chestertield Road.*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None.

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 30 1946* at *9:00 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *May 15 1946* to *May 30 1946* and that I last saw him alive on *May 15 1946*

Immediate cause of death

Heart failure

DURATION

2 mos

Due to *Arteriosclerotic*

Heart disease

years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

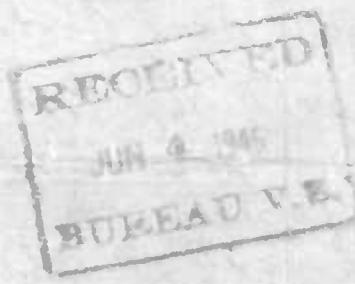
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *John Williams MD*

M. D. or other

Address *Annapolis Md* Date signed *5-30-46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13d

04500

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County.....

A.A.

City or town.....

Jewell

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles E. Gray.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

c.

Married

B. (b) Name of husband or wife

Mary Gray.

6. (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.)

May 10, 1888

8. AGE:

Years
58

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Md.

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

Andrew Gray.

FATHER

12. Name.....

Md.

13. Birthplace.....

Rachelle Peters.

MOTHER

14. Maiden name.....

Md.

15. Birthplace.....

Md.

16. Informant.....

Mary Gray.

Address

Jewell, Md.

17. Burial.....

Date thereof 6-2-46
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory

Mt Zion

Location

A.A. County.

18. Funeral director.....

P. E. Sewell

Address

Prince Frederick

19. Date rec'd by registrar

May 31 1946

M.T. Claytor

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

A.A.

City or town.....

Jewell

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

5-30 1946 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-Jan 1946 to 5-30 1946

and that I last saw h. him alive on 5-21 1946

Immediate cause of death.....

Chronic myocarditis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

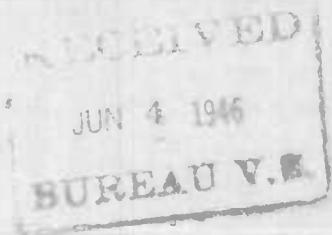
Means of injury.....

Injured at work?

23. SIGNATURE

Date signed May 31 1946

Address Heslington W. Va.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

04501

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County A. F. C. Camp
City or town Chesapeake Station
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of
deceased (mo., day, yr.)6. (c) If alive, give age 51 years

8. AGE:

Years 57 Months Days If less than one day
hrs. min.

9. Birthplace

Frederick Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

Lessons of A. Gray

12. Name

Frederick Co. Md

13. Birthplace

Stella C. Young

14. Maiden name

Frederick Co. Va.

15. Birthplace

Grace Gray

16. Informant

Robert St. Patapes Park

17. Address

5-6-46
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Mt. Auburn Cemetery

Location

Baltimore Md

18. Funeral director

Archibald A. Gaddis

Address

2101 Mt. Auburn St. Balt.

19. (Date rec'd by registrar)

5/6/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County H.A.C.City or town Chesapeake Station
(If outside city or town limits, write RURAL and give nearest town)Street No. Robert St. Patapes Park
(If rural, give LOCATION)2.(a) If veteran, name war World War One

3. (b) Social Security Number

217-05-4626

MEDICAL CERTIFICATION

2D. DATE OF DEATH 5-3-46 19..... at 8:00 a.m. M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
2-15 1946 to 5-3 1946and that I last saw h. m. alive on 5-3-46 1946Immediate cause of death Cerebral Hemorrhage DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Julius S. White M. D. or otherAddress 1802 Penn Ave Date signed 5-6-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

04502

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

Anne Arundel

County.....

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

1 hour, 44 minutes

How long in above place of death?

Hospital, institution, or street address where death occurred:

Annapolis Emergency Hospital

How long in hospital or institution? 1 hour, 44 minutes

3. (a) FULL NAME

Dennis Harold

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

Colored

Married

6.(b) Name of husband or wife.....

Lera Harold

7. Birth date of deceased (mo., day, yr.)

December 25, 1890

6.(c) If alive, give age

54

years

8. AGE:

Years

Months

Days

If less than one day

55

4

22

.

hrs.

.

min.

9. Birthplace.....

Portsmouth, Virginia

(Town, county, and state)

10. Usual occupation.....

Skilled laborer

11. Industry or business

Shipyards

12. Name.....

Raleigh Harold

13. Birthplace

Portsmouth, Virginia

14. Maiden name.....

Martha Harold (Maiden name ?)

15. Birthplace

Portsmouth, Virginia

16. Informant.....

Margaret Harold - daughter

Address

Brown's Wood, Maryland.

17. Burial.....

Burial Date thereof.....

(month)

(day)

(year)

(Burial, cremation, or removal. Which?)

Broadneck

Cemetery or crematory.....

St. Margaret's

Location.....

J.B. Johnson

18. Funeral director.....

C. J. Johnson

Address

C. J. Johnson

19. (Date rec'd by registrar)

May 21, 1946

(Date rec'd by registrar)

Registrars

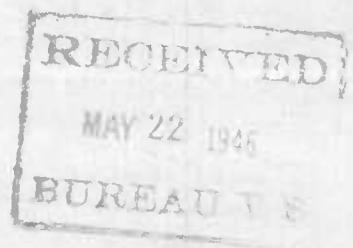
Signature _____ M.D. or other _____

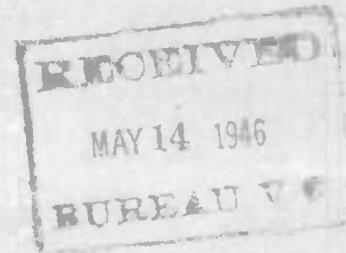
Address _____ Date signed _____

23. SIGNATURE

Signature _____ M.D. or other _____

Address _____ Date signed _____





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 307

04504

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
Anne Arundel County
County.....
Crownsville, Maryland
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

Crownsville State Hospital

How long in hospital or institution?.....

1 month, 17 days

3. (a) FULL NAME

HILL - LAURA LEE

4. Sex female	5. Color or race black	6. (a) Single, married, widowed, or divorced widow
------------------	---------------------------	---

8. (b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.) 1903

8. AGE: Years 43	Months unknown	Days -----	If less than one day ----- hrs. ----- min.
---------------------	-------------------	---------------	---

9. Birthplace..... Maryland
(Town, county, and state)

10. Usual occupation..... Housework

11. Industry or business.....

12. Name..... Theodore Thomas

13. Birthplace..... unknown

14. Maiden name..... Elma Williams

15. Birthplace..... unknown

16. Informant..... Hospital Records

Address..... Crownsville, Maryland

17. Buried..... Date thereof May 15, 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Rose Hill

Location..... Hagerstown, Maryland

18. Funeral director..... Fred W. Kraiss

Address..... Hagerstown, Maryland

19. May 13, 1946. B. F. Joyce, Registrar
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington

City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No..... unknown

(If rural, give LOCATION) ✓

2. (a) If veteran, name war.....

3. (b) Social Security Number

unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 12, 1946, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
March 25, 1946, to May 12, 1946, and that I last saw her alive on May 12, 1946.

Immediate cause of death..... General Paresis

Due to..... Known to us since 3/25/46

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Crownsville, Maryland Date signed 5/12/46

RECEIVED
MAY 16 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

04505

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County..... Anne Arundel
 City or town..... Annapolis ~~Suburb~~ A. A. Co. Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Unknown

Hospital, institution, or street address where death occurred:

Emergency Hosp. Annapolis Md.

How long in hospital or institution?..... Entered 5/11/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... West River A. A. Co. Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... None

(If rural, give LOCATION)

None

2.(a) If veteran, name war.....

3. (a) FULL NAME

Evelyn Brown Howard

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced

Female Col. Married

6.(b) Name of husband or wife..... Walter Howard

7. Birth date of deceased (mo., day, yr.)..... 8. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
42 9 hrs. min.9. Birthplace..... Arnold A. A. Co. Md.
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... None

12. Name..... Elijah Brown

13. Birthplace..... Severn A. A. Co. Md.

14. Maiden name..... Mary Jane Marshall

15. Birthplace..... Arnold A. A. Co. Md.

16. Informant..... Mrs Louise Johnson

Address 43 Larkins St. Annapolis Md.

17. Burial..... Date thereof..... 5/16/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Calvary Arnold Md.

Location..... Mt. Calvary Church Cemetery Arnold Md.

18. Funeral director..... Mrs Charles E. Hicks

Address 45 Northwest St. Annapolis Md.

19. May 16, 1946
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that it was from
 Post mortem examination
 cause of death.....

Immediate cause of death.....

Concussion of Brain
 Hemorrhage & shock
 Due to..... Fracture of both tibia
 Due to..... Fracture of left humerus

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... accident Date of 5/11/46

Where did injury occur? Deale Road A. H. Maryland
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Deale Road

Means of injury cut & run auto collision Injured at work? Yes

23. SIGNATURE..... John M. Daffey, M.D. Deputy medical examiner
 Address..... Annapolis Md. M. D. or other

Date signed 5/15/46

RECEIVED

MAY 18 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04506

Reg. Dist. No. 27

1. PLACE OF DEATH:
Anne Arundel
County

City or town Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Regional Hospital, Ft. Geo. G. Meade, Md.

How long in hospital or institution? 3 Months and 14 Days

3. (a) FULL NAME
JOHN J. JACOBY (RA 6,687,850)

4. Sex White Male 5. Color or race Single 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife (Sister) Mrs. Bernice Campbell,
77 Lilac St., New Haven, Conn.

7. Birth date of deceased (mo. day, yr.) June 19, 1908

8. AGE: Years Months Days If less than one day
37 10 21 hrs. min.

9. Birthplace New Haven, Connecticut
(Town, county, and state)

10. Usual occupation Soldier, U. S. Army (Technical)

11. Industry or business Regular Army /Sergeant

MOTHER FATHER 12. Name Stanley Jakubowicz

13. Birthplace Wroclaw, Poland

14. Maiden name Aniela Niziolek

15. Birthplace Wroclaw, Poland

16. Informant U.S. Army Medical and Service Records

Address Fort George G. Meade, Maryland

17. Burial, cremation, or removal? Resumed Date thereof 5/11/46
(month) (day) (year)

Cemetery or crematory Markiewicz Funeral Parlor

Location Trumball St., New Haven, Connecticut

18. Funeral director Howard W. Blight Jr.

Address 4914 Belair Road

19. Date rec'd by registrar 10 May 1946
ALLAN G. BROTHMAN, 2d Lt. MAC registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State New York County

City or town Johnson City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 440 Riverside Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 May, 1946 at 1110 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

26 Jan 1946 to 12 Feb 1946
and that I last saw him alive on 10 May 1946

Immediate cause of death

Ruptured gastric

rectix

Due to Severe vomiting

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy result Hemorrhage, acute, origin gastro-

PYSCIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

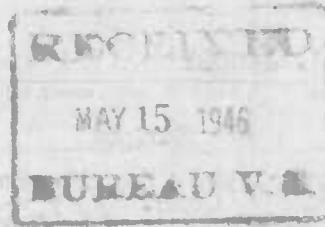
Means of Injury Injured at work?

*intestinal tract. Probably stomach.

23. SIGNATURE Frank W. COUNTRYSMAN, 1st Lt. MC

M. D. or other

Address Reg. Hosp., Ft. G. G. Mead Date signed 13 May 46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(Bd)*

04507

CERTIFICATE OF DEATH ★Reg. Dist. No. *28*

1. PLACE OF DEATH:

Anne Arundel County

County

Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

16 yrs, 1 mo, 16 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

16 yrs, 1 mo, 16 days

How long in hospital or institution?

3. (a) FULL NAME

JOHNSON - CLARA

4. Sex female	5. Color or race black	6. (a) Single, married, widowed, or divorced married
------------------	---------------------------	---

6. (b) Name of husband or wife..... unknown

7. Birth date of
deceased (mo., day, yr.) 1884

8. AGE: Years 62	Months unknown	Days -----	If less than one day ----- hrs. ----- min.
---------------------	-------------------	---------------	--

9. Birthplace..... Maryland
(Town, county, and state)

10. Usual occupation..... Domestic

11. Industry or business.....

MOTHER FATHER	12. Name..... Edward Rounds
	13. Birthplace..... Maryland

MOTHER	14. Maiden name..... Sarah E. Horsey
	15. Birthplace..... Maryland

16. Informant..... Hospital Records

Address..... Crownsville, Maryland

17. Burial..... Date thereof..... May 21-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Someret Co

Location..... near Marion MD

18. Funeral director..... Chas. H. Ward

Address..... Marion MD

19. May 18 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Somerset

City or town..... Marion
(If outside city or town limits, write RURAL and give nearest town)

Street No..... unknown

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 17

1946 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 31 1946 to May 17 1946

and that I last saw her alive on May 17 1946

Immediate cause of death.....

Chronic Myocarditis

DURATION

Known to us about

Due to.....

Due to.....

Other conditions..... Schizophrenia - Paranoid type

Known to us since

(Include pregnancy within 3 months of death)

3/31/30

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

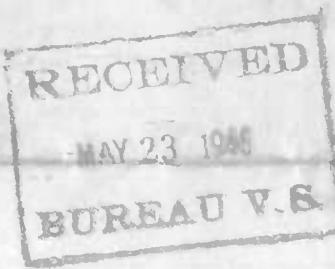
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Crownsville, Maryland Date signed 5/17/46



121
John

evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

04508

FILM No. 104 MAY 27 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County.....

City or town.....

Anne Arundel
Rural, Brownwood, Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

George C. Johnson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

colored

married

8. (b) Name of husband or wife.....

Mary E. Johnson

7. Birth date of

deceased (mo., day, yr.)

8. (c) If alive, give age..... years

Nov. 13, 1889

8. AGE:

Years

Months

Days

If less than one day

57

56

6

4

hrs.

min.

10. Usual occupation.....

Laborer

11. Industry or business

12. Name.....

Jesse Staudbury

13. Birthplace.....

A. A. Co.

14. Maiden name.....

Armitia Johnson

15. Birthplace.....

A. A. Co.

16. Informant.....

Mary Johnson

Address

R. 2 Annapolis Md.

Burial

Date thereof.....

May 17, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

May 17, 1946

17. Cemetery or crematory.....

Broadmeadow

Location

Baltimore, Md.

18. Funeral director.....

J.B. Johnson

Address

Annapolis Md.

19. Date rec'd by registrar.....

May 17, 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Anne Arundel

City or town.....

Brownwood R. 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 14, 1946

at 2:17 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 6, 1946

to *May 14, 1946*

and that I last saw h..... alive on *May 14, 1946*

19.

Immediate cause of death.....

Apoplexy

Due to.....

Hypertension

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Herde H. Johnson M.D.

M. D. or other

Address..... Date signed.....

5/16/46

RECEIVED

MAY 21 1946

BUREAU V.S.

Johnson

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

04509

CERTIFICATE OF DEATH

Reg. Dist. No. *21*

1. PLACE OF DEATH:

County *Anne Arundel* City or town *Baltimore, Rural*
If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Irene Johnson

4. Sex *Female* 5. Color or race *Colored* 6. (a) Single, married, widowed, or divorced *widow*

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *Feb. 7, 1878*

8. (c) If alive, give age years

8. AGE: Years *68* Months *2* Days *29* It less than one day *hrs. min.*

9. Birthplace *O.A.*

(Town, county, and state)

10. Usual occupation *Domestic*

11. Industry or business

12. Name *Thomas Brown*

13. Birthplace *O.A.*

14. Maiden name *Rosetta Brown*

15. Birthplace *O.A.*

16. Informant *Hester Walker*

Address *Brownwood Rd P. 2 Box 420*

17. Burial Date thereof *May 9, 1946*
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory *Broadmead, Bever Hill*

Location *Baltimore, MD Baltimore*

18. Funeral director *J.B. Johnson*

Address *Baltimore, MD*

19. *May 9, 1946* (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MD* County *Anne Arundel*

City or town *Baltimore, Rural Brownwood*
If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 6, 1946* at *1 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 4, 1946 to *May 6, 1946*, and that I last saw her alive on *May 6, 1946*.

Immediate cause of death

Apolysis

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

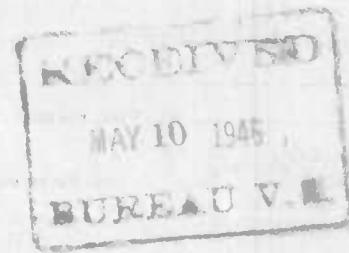
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *J.H. Johnson, M.D.* M. D. or other

Address *40 Madison Street* Date signed *5/8/46*

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

04510

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County... Anne Arundel
City or town... Mt. Rd., Pasadena Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Walter D. Klingelhoefer

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife...

Ethel J.

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

April 7 1900

8. AGE:

Years
46Months
1Days
10

If less than one day

hrs. min.

9. Birthplace.....

Baltimore Md.

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

MOTHER FATHER
12. Name..... Wm. W. Klingelhoefer
13. Birthplace..... Baltimore Md.MOTHER
14. Maiden name..... Julia Henry

15. Birthplace..... Baltimore Co.

16. Informant.....

Mrs. Ethel J. Klingelhoefer

Address

Pasadena Md. Mountain Rd.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof.... May 21 46

(month) (day) (year)

Cemetery or crematory.....

Glen Haven Memorial Cem.

Location.....

Ricke Highway

18. Funeral director.....

Clarence Hoffman

Address

1639 N. Broadway

19. (Date rec'd by registrar)

5-17-46

L. d. Bleit

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

Md.

State.....

County.....

Pasadena Md.

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Mt. Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

May 17

46

at 10.15 AM

20. DATE OF DEATH.....
March 27 1946 to May 17 1946
and I last saw him alive on May 13 1946

Immediate cause of death.....

Carcinoma of stomach

Generalized metastatic carcinomatosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations..... inoperable carcinoma with many metastases..... Date of op. Jan. -46

Autopsy results..... (gastro-enterostomy)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

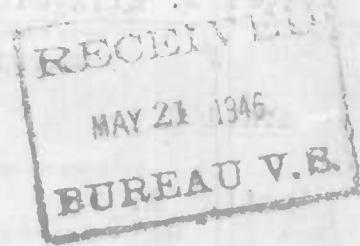
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

L. d. Bleit, M.D.
Pasadena, Md. 5-17-46
M. D. or other
Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore LSH

04511

21

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Annapolis

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *3 1/2 years*

Hospital, institution or street address where death occurred:

79 Spa Road

How long in hospital or institution?

3. (a) FULL NAME

Charles S Koch

4. Sex

M

5. Color or race

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

*Frieda Koch*6. (c) If alive, give age *73* years

7. Birth date of deceased (mo., day, yr.)

Jan 24 - 1867

8. AGE:

Years

Months

Days

It less than one day
hrs. min.*79*

9. Birthplace

Germantown

(Town, county, and state)

10. Usual occupation

Painter

11. Industry or business

MOTHER / FATHER

Geo S. Koch

12. Name

Germann

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Frieda Koch

17. Burial

Address *79 Spa Road Annapolis*
(Burial, cremation, or removal. Which?) Date thereof *May 12/46*
(month) (day) (year)

Cemetery or crematory

Cedars Sleep

Location

Annapolis Md

18. Funeral director

B. L. Flipping

Address

Annapolis Md

19. (Date rec'd by registrar)

May 11 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. *49 Spa Road*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *5-10-46* 1946 at *9:20 AM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jane 1946 to *May 10 1946* 1946and that I last saw her *alive* on *May 9 1946* 1946

Immediate cause of death

Odema lungs DURATION *48 hrs*Due to *Chronic Bright's* (No pleuris)

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE *J. J. Russell*

M. D. or other

Address *Eastport Md* Date signed *5-10-46*

RECEIVED

MAY 14 1945

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

04513

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County.....

City or town.....Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....45 years

Hospital, institution, or street address where death occurred:

Emergency HospitalHow long in hospital or institution?.....5 weeks

3. (a) FULL NAME

Mat Kolgin

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MWMarried8. (b) Name of husband or wife.....Willie Kolgin6. (c) If alive, give age.....62 years

7. Birth date of

deceased (mo., day, yr.)

July 15 1876

8. AGE:

Years

Months

Days

If less than one day

691010

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Russia

10. Usual occupation.....

Petited

11. Industry or business

12. Name.....Herbert Kolgin

13. Birthplace.....

Russia14. Maiden name.....Unknown

15. Birthplace.....

Unknown16. Informant.....Herbert Kolgin

Address

22 Steele St Annapolis

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof.....May 26/46

(month) (day) (year)

Cemetery or crematory.....Knesseth Israel

Location.....

Best Gate18. Funeral director.....B. L. Hopping

Address

Annapolis19. Date rec'd by registrar.....May 25 46

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MarylandCounty.....AnnapolisCity or town.....Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 239 west

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....5/25

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/29 1945 to 5/25 1946and that I last saw him alive on 5/25 1946

Immediate cause of death.....

Carcinoma of Stomach & Metastasis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings at operation.....

Carcinoma of Stomach & Metastasis date of op. 1/10/46

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

3. SIGNATURE.....Mr. Klavans M.D.

M. D. or other

Address.....Annapolis Md

Date signed

RECEIVED

MAY 28 1946

BUREAU V.8

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04513

28

Reg. Dist. No.

1. PLACE OF DEATH: Anne Arundel County
County.....

City or town..... Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs., 6 mos., 24 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 7 yrs., 6 mos., 24 days

3. (a) FULL NAME

LEWIS - ESTHER

4. Sex female	5. Color or race black	6. (a) Single, married, widowed, or divorced single
------------------	---------------------------	--

8. (b) Name of husband or wife.....

5. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years 31	Months unknown	Days -----	If less than one day ----- hrs. ----- min.
---------------------	-------------------	---------------	--

9. Birthplace..... Maryland
(Town, county, and state)

10. Usual occupation..... Domestic

11. Industry or business.....

12. Name..... Frank Lewis
13. Birthplace..... West Virginia

MOTHER / FATHER	14. Maiden name..... May Jones
	15. Birthplace..... Maryland

16. Informant..... Hospital Records

Address..... Crownsville, Maryland

17. Buried..... Date thereof..... May 8, 1946
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Mt. Calvary

Location..... Anne Arundel County

18. Funeral director..... George G. Kelson

Address..... 1303 Presstman Street, Baltimore, Md.

19. 5-7..... 46..... Auged with
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1147 North Mount Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 5 1946 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 11 1938 to May 5 1946

and that I last saw her alive on May 5 1946

Immediate cause of death.....

Lung Tuberculosis

DURATION Known to us since

2/15/45

Due to.....

Due to.....

Other conditions..... Epilepsy with Psychosis Known to us since

10/11/38

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

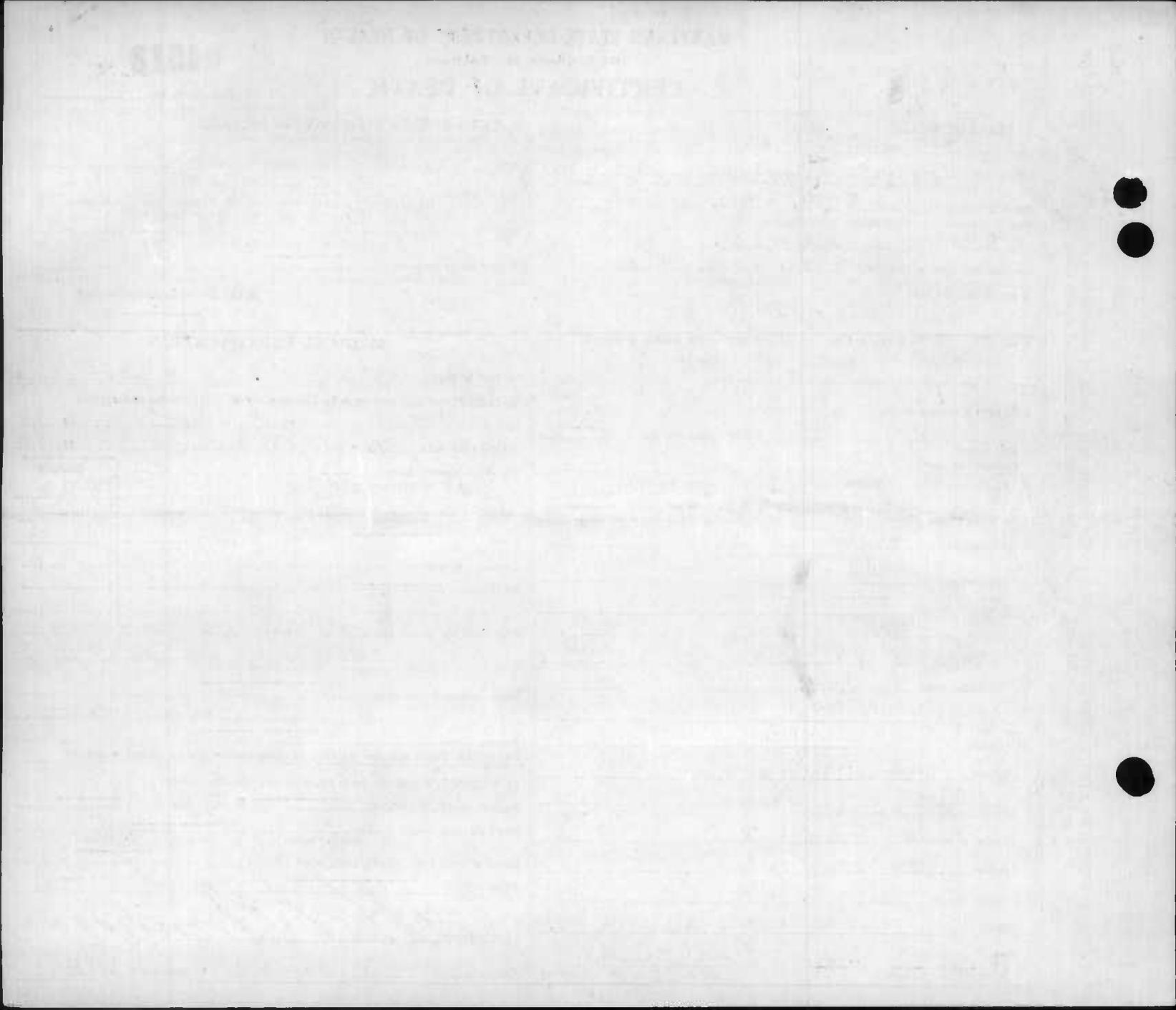
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Crownsville, Maryland v. Date signed..... 5/5/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

04514

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County.....

City or town..... *Eastport*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *6 years*

Hospital, institution, or street address where death occurred:

1018 San Bruno St

How long in hospital or Institution?

3. (a) FULL NAME

alice Wiley Linton

3. (b) Social Security Number

4. Sex *F*5. Color or race *w*6. (a) Single, married, widowed, or divorced *widow*6. (b) Name of husband or wife *Clarence Linton*6. (c) If alive, give age *years*7. Birth date of deceased (mo., day, yr.) *Feb 26 - 1884*8. AGE: Years *62* Months *2* Days *25*Less than one day *hrs. min.*9. Birthplace *Balto. Md*

(Town, county, and state)

10. Usual occupation *wife*

11. Industry or business

12. Name *William Larkins*13. Birthplace *Balto. Md*14. Maiden name *Mary L. Lee Linton*15. Birthplace *Balto. Md*16. Informant *W. Emerson Wiley*Address *Eastport, Maryland*17. Burial, cremation, or removal, Which? *Funeral*Date thereof *May 23/46*
(month) (day) (year)Cemetery or crematory *Quaker*Location *Salesville, Md*18. Funeral director *B & H Cappin*Address *Annapolis, Md*19. Date rec'd by registrar *May 23 1946*

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Anne Arundel*City or town *Eastport*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *1018 San Bruno*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 21/46* 19th at *9:00 a.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 46 19th to *May 21 1946*and that I last saw her alive on *May 21 1946* 19th.

Immediate cause of death

*Myocarditis chv.**Uterine*Due to *Chr obstructed birth*

DURATION

*4 years**3 days**2 years*

Due to

*uterine fibromas**uterine bleeding**several weeks**several days*

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE *George C. Rosil*

M. D. or other

Address *Annapolis, Md* Date signed *5-22-46*

Register

RECEIVED

MAY 24 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-6

04515

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County..... a. a.s.

City or town..... Edgewater

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred:

Oakwood Ave 4612

How long in hospital or institution?.....

3. (a) FULL NAME

Anna May Lowe

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Robert E. Lowe

7. Birth date of deceased (mo., day, yr.) Oct 17 - 1885 8. (c) If alive, give age 59 years

8. AGE: Years Months Days If less than one day
60 1 14 hrs. mln.

9. Birthplace Erie Pa (Town, county, and state)

10. Usual occupation house wife

11. Industry or business

12. Name William Abbott

13. Birthplace England

14. Maiden name Anna Whelam

15. Birthplace England

16. Informant Robert E. Lowe

Address Woodland Beach

17. Burial Date thereof Jan 3/46
(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory St Mary's

Location Annapolis Md

18. Funeral director B. L. Thompson

Address Annapolis Md

19. June 3, 1946 Edward Collemon
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a.s.

City or town Edgewater Post office

(If outside city or town limits, write RURAL and give nearest town)

Street No. Oakwood Ave 4612

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1946 at 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1, 1945 to May 31, 1946, and that I last saw her alive on May 31, 1946.

Immediate cause of death

Cerebral hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

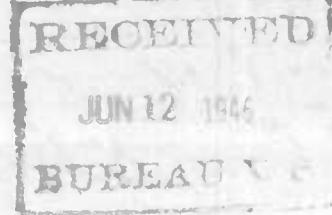
Means of injury

Injured at work?

23. SIGNATURE

Albert E. Anderson M.D. or other

Address Annapolis, Md Date signed 6/1/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4-1020

CERTIFICATE OF DEATH

045162

Reg. Dist. No. 52

1. PLACE OF DEATH:

County.....

City or town.....

A. H. C.

Jessup, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred.....

Champion Forest

How long in hospital or institution?.....

3. (a) FULL NAME

Ella Grace Malone

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife.....

Marion R. Malone

7. Birth date of deceased (mo., day, yr.)

December 5, 1903

deceased (mo., day, yr.)

47 years

(c) If alive, give age

Years

Months

Days

If less than one day

42

4

28

hrs.

hrs.

min.

8. Birthplace.....

Washington, D.C.

(Town, county, and state)

9. Usual occupation.....

Huf.

10. Industry or business.....

Chas. J. Mac Murray

MOTHER FATHER

12. Name.....

Ellen Boyce

13. Birthplace.....

Washington, D.C.

14. Maiden name.....

Ellen Boyce

15. Birthplace.....

Winnipeg, Canada

16. Informant.....

Mr. Marion R. Malone

Address.....

Jessup, Md.

17. Burial.....

Cedar Hill, P. S. Co., Md.

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

Lloyd Kaiser

18. Funeral director.....

Kaufel, Md.

Address.....

Blair Hospital

19. Date rec'd by registrar.....

Blair Hospital

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 4th 1946, at 12⁰⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 4, 1946, to May 4, 1946, and that I last saw her alive on May 3rd 1946.

Immediate cause of death.....

Abdominal Carcinomatosis

DURATION
3 mos.

Due to.....

Carcinoma of Ovary

DURATION
1 yr.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Carcinoma of Ovary

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

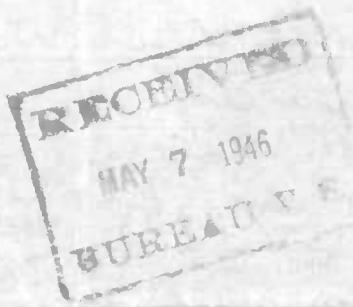
23. SIGNATURE.....

Frank Shiley M.D.

Address.....

Savage, Md.

Date signed 5/14/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct type is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

04517
v3

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel

City or town Bel Air, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

118 - 1 Avenue South

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Carrie May Miller

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W.

Widow

6. (b) Name of husband or wife

Herritt P. Miller

8. (c) If alive, give age dead years

7. Birth date of deceased (mo., day, yr.)

May - 8 - 1863

8. AGE:

Years 83

Months 0

Days 19

It less than one day hrs. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Jefferson Steigman

FATHER

12. Name

Maryland

13. Birthplace

Maryland

MOTHER

14. Maiden name

Elizabeth Helm

15. Birthplace

Maryland

16. Informant

Miss Estelle Rice (cousin)

Address

Bel Air, Md.

17. Burial

Date thereof 5/29/46

(Burial, removal, etc.) (month) (day) (year)

Cemetery or crematory

Arid Ridge

Location

P. Kesville, Md.

18. Funeral director

William Cook Inc.

Address

127 St. Paul St.

19. (Date signed by registrar)

5/28/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2613 Bedford Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1946 at 1 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 18 1946 to May 27 1946

and that I last saw her alive on May 26 1946

Immediate cause of death

Cerebral Hemorrhage

Due to Hypertension

Due to Arteriosclerosis and Tendinitis

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Gustave H. Pauley Jr.

M. D. or other

Address Bel Air, Md. Date signed 5/27/46

Registrar

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 306

CERTIFICATE OF DEATH

04518

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Anne Arundel County
City or town Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs, 4 mos, 18 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital
8 yrs, 4 mos, 18 days

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville (If outside city or town limits, write RURAL and give nearest town)

Street No. unknown

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MOTEN - RICHARD PHILIP

4. Sex male 5. Color or race black 6.(a) Single, married, widowed, or divorced married

B.(b) Name of husband or wife Mary Moten, Rockville, Md.

unk

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years 32 Months unknown Days If less than one day hrs. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Farm Worker

11. Industry or business

MOTHER FATHER 12. Name John Moten
13. Birthplace Virginia

MOTHER 14. Maiden name Julia Nelson

MOTHER 15. Birthplace unknown

16. Informant Hospital Records

Address Crownsville, Maryland

17. Buried Cemetery or crematory Date thereof May 23, 1946
(Burial, cremation, or removal. Which?) Lincoln Park

Location Near Rockville, Maryland

18. Funeral director Robert L. Snowden

Address Rockville, Maryland

19. (Date rec'd by registrar) May 21, 1946 E.T. Joyce Local Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20

19 46 at 10:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 2, 1945 19 to May 20 19 46
and that I last saw h. im alive on May 20 19 46

Immediate cause of death

General Paresis

DURATION

Known to us since 1/2/44

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

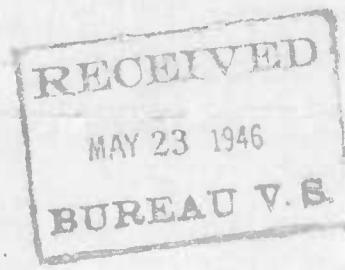
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Crownsville, Maryland Date signed 5/20/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

04519

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH: Anne Arundel
 County: Odenton
 City or town: Odenton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 weeks
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Anne Arundel
 City or town: Odenton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: 5th Avenue
 (If rural, give LOCATION)

3. (a) FULL NAME

William A. Nichols, Sr.3. (b) Social Security Number
None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>white</u>	<u>Married.</u>
<u>Florence G. Nichols</u>		
6. (b) Name of husband or wife <u>Nee Gray</u>		
6. (c) If alive, give age <u>51</u> years		
7. Birth date of deceased (mo., day, yr.) <u>January 31, 1878</u>		
8. AGE: Years <u>68</u> Months <u>3</u> Days <u>5</u> less than one day hrs. min.		

9. Birthplace: Connecticut
 (Town, county, and state)
 10. Usual occupation: Wood Pattern Maker (Retired)

11. Industry or business
 MOTHER FATHER
 12. Name: George B. Nichols
 13. Birthplace: CONNECTICUT
 MOTHER
 14. Maiden name: Louella Fish
 15. Birthplace: CONNECTICUT

16. Informant: Mrs. William A. Nichols
 Address: Odenton Ma. R.F.D.
 17. Burial: Buryia! Date thereof: May 7, 1946
 (Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or crematory: Glen Haven
 Location: Glen Burnie, Md
 18. Funeral director: Thomas W. Singlton
 Address: Glen Burnie Md

19. Date rec'd by registrar: 5/11/46 M. D. or other
 (Date rec'd by registrar) Address: McAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 1946 at 10:58 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 1, 1946 to May 5, 1946
 and that I last saw him alive on May 4, 1946

Immediate cause of death:

central arteriosclerosis ?

Due to:

Tenacity

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of _____

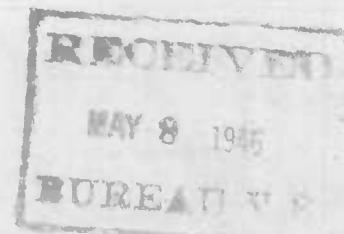
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE: Gustave K. Pauley, Jr.
 M. D. or other
 Address: Glen Burnie Md Date signed: 5/6/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

CERTIFICATE OF DEATH

04520
28

Reg. Dist. No.

1. PLACE OF DEATH:

Anne Arundel County

County

Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

18 yrs, 1 mo, 15 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

18 yrs, 1 mos, 15 days

How long in hospital or institution?

3. (a) FULL NAME

PENNINGTON - LENA

4. Sex

female

5. Color or race

black

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

June 23, 1894

8. AGE:

Years

Months

Days

If less than one day

51

11

2

----- hrs.

----- min.

9. Birthplace.....

(Town, county, and state)

Domestic

10. Usual occupation.....

11. Industry or business.....

Charles Pennington

FATHER

12. Name.....

Maryland

MOTHER

13. Birthplace.....

Sarah Byrd

MOTHER

14. Maiden name.....

Virginia

15. Birthplace.....

Hospital Records

16. Informant.....

Crownsville, Maryland

Address

Burial, cremation, or removal, Which?

Date thereof.....
(month) (day) (year)
6-25-6

Cemetery or crematory

Hospital

Location

Crownsville Md

18. Funeral director.....

Rept.

Address

Crownsville Md

19. June 5 1946 Ent Joyce local

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State

County

Baltimore City

City or town

(If outside city or town limits, write RURAL and give nearest town)

1428 Bruce Street

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 25

19. 46

at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10

19. 28

to May 25

19. 46

and that I last saw her alive on May 25

19. 46

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

Known to us since

Feb. 1946

Due to.....

Due to.....

Other conditions..... Psychosis with Mental

Known to us since

Deficiency plus Alcoholism

(Include pregnancy within 3 months of death)

4/10/28

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

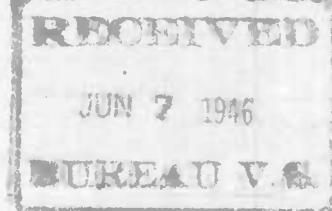
23. SIGNATURE.....

M. D. or other

Crownsville, Maryland

5/25/46

Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
Anne Arundel County
County.....
City or town.....Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....6 months, 6 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution?.....6 months, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
Maryland
State.....County.....
Baltimore City
City or town.....Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
552 Dolphin Street
Street No.....
(If rural, give LOCATION)

3. (a) FULL NAME
PETTIFORD - IRENE

3. (b) Social Security Number
unknown

4. Sex female | 5. Color or race black | 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 1894 | 6.(c) If alive, give age years

8. AGE: Years 52 | Months unknown | Days | If less than one day
hrs. min.

9. Birthplace Michigan
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Joseph A. Pettiford

13. Birthplace Illinois

MOTHER FATHER

14. Maiden name Mable A. Ridgeley

Michigan

16. Informant Hospital Records

Address Crownsville, Maryland

17. Buried Date thereof May 14, 1946
(Burial, cremation, or removal. Which?)

Cemetery or crematory
Location Kalamazoo, Michigan

18. Funeral director Mrs. Frances A. Hensley

Address 578 West Biddle St., Balto., Md.

19. May 10, 1946 E. Joyce Local
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 | 19 46 at 6:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2 | 19 45 to May 8 | 19 46
and that I last saw her alive on May 8 | 19 46

Immediate cause of death General Paresis
DURATION Known to us since 11/2/45

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

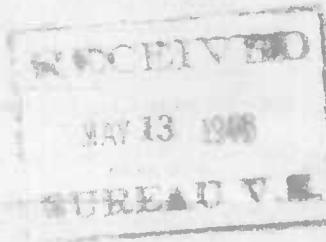
Where did injury occur?.....(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address Crownsville, Maryland Date signed 5/8/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

04522

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County

City or town

Anne Arundel
Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sex

Female White Widow

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

12. Name

MOTHER FATHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

May 21 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Maryland Anne Arundel
Annapolis Md.
59 Annes Garrett Blvd.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May, 1946 at 445 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19 1946 to same date

and that I last saw her alive on not

Immediate cause of death acute heart failure

Due to coronary heart disease about 2 years

or angina pectoris

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

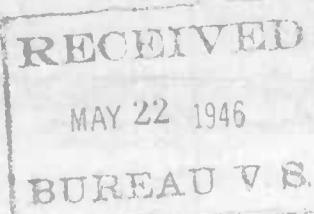
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE

Edith Rodger M.D. M. D. or other

Address 92 State Circle Date signed 5-22-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16A

05302

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County Anne Arundel
City or town Severn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Few seconds

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Charles Francis Piech

4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1/20/28 6.(c) If alive, give age years

8. AGE: Years 18 Months 3 Days 9 If less than one day hrs. min.

9. Birthplace Bayonne, N.J. (Town, county, and state)

10. Usual occupation Soldier

11. Industry or business John Piech

MOTHER FATHER 12. Name John Piech

13. Birthplace Poland

14. Maiden name Mary S. Salomon

15. Birthplace Poland

16. Informant U.S. Army Records

Address Fort Meade, Md.

17. Removal Date thereof 5/4/46
(Burial, cremation, or removal. Which?)

Cemetery or crematory Matthew Maliszewski Funeral

Location New Brunswick, N.J.

18. Funeral director Howard J. Blight

Address 4914 Belair Road

19. 4 May, 1946 ALLAN G. BROTHMAN, Lt. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New Jersey County Monmouth

City or town Pasture (If outside city or town limits, write RURAL and give nearest town)

Street No. 14 Union St.

(If rural, give LOCATION)

2.(a) If veteran, name war (Soldier, U.S. Army) ✓

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 2nd 1946 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. — alive on 19.

Immediate cause of death Compound fracture of skull -

DURATION Sudden

Due to Fall off Train P.R.R. No. 142

Due to Roll back bound.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Confirmed as above in addition to*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

*Punctured heart, spleen and liver.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5/4/46

Where did injury occur? Severn, Md. (City or town) (State)

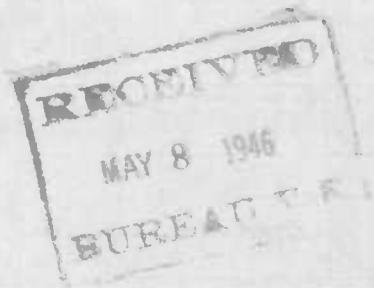
Injured at home, farm, industry, public place (where?) Railroad

Means of injury Fall off train Injured at work? No

23. SIGNATURE Gustave H. Piech, M.D.

Assistant medical examiner M.D. or other

Address Internal Bureau, T.M.S. Date signed 5/5/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B)

04523

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

39 yrs

Hospital, Institution, or street address where death occurred.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife.....

Katherine T.

7. Birth date of deceased (mo., day, yr.)

Sept 8th 1877

8. (c) If alive, give age..... years

8. AGE:

Years
68.Months
8.Days
20If less than one day
hrs. min.

9. Birthplace.....

(Town, county, and state) Md.

10. Usual occupation.....

Farmer

11. Industry or business

Self.

Richard P. Bedmiles

12. Name.....

Richard P. Bedmiles

13. Birthplace

Md.

14. Maiden name.....

Mary M.

15. Birthplace

Md.

16. Informant.....

Mrs. Katherine T. Bedmiles

Address

Telegraph Rd.

Smyrna, Md.

17. Burial

Date thereof

6/1/46

(month) (day) (year)

(Burial, cremation, or removal. Which?)

New Cathedral Cem.

Location

4300 Old Frederick Rd.

18. Funeral director

John Coward & Son

Address

Jefferson St.

50-03 Residences

19. Date of death / registrar

31 1946

(If not a registrar)

Mrs. Alva

Signature

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County..... Anne Arundel

City or town.....

Smyrna

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Telegraph Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5/28/1946 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-27-46 to 5-28-46

and that I last saw him alive on 5-28-46

Immediate cause of death.....

Acute Coronary Thrombosis

Due to.....

Due to.....

Other conditions.....

Cardiac arrest due to coronary thrombosis

(Includes pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

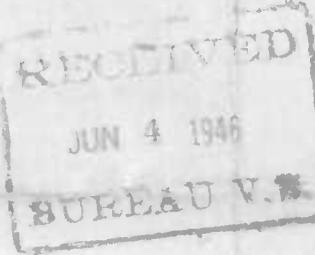
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other _____ Date signed _____

Address..... Cleaton May 20-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 304

04524 P

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....Annie Arundel County
 City or town.....Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

18 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Crownsville State HospitalHow long in hospital or institution? 18 days

3. (a) FULL NAME

SCOTT - ARCHIBALD H.

4. Sex male	5. Color or race black	6.(a) Single, married, widowed, or divorced married
----------------	---------------------------	--

6.(b) Name of husband or wife.....Elfrieda Scott, Eastern
 Ave., Chase, Md.

6.(c) If alive, give age.....unk. years

7. Birth date of deceased (mo. day, yr.)
July 3, 1886

8. AGE: Years 59	Months 10	Days 13	If less than one day — hr. — min.
---------------------	--------------	------------	---

9. Birthplace.....Maryland
 (Town, county, and state)

10. Usual occupation.....Merchant11. Industry or business.....unknown12. Name.....Archibald Scott13. Birthplace.....Maryland14. Maiden name.....Rosie ?15. Birthplace.....Maryland16. Informant.....Hospital RecordsAddress.....Crownsville, Maryland

17. Buried.....May 19, 1946
 (Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....Sharp Street Cemetery
 Location.....Chase, Baltimore County, Maryland

18. Funeral director.....Mrs. Rob. Elliott & DaughterAddress.....1129 N. Caroline St., Baltimore, Md.

19. (Date rec'd by registrar)
5/20/46 Archibald

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....BaltimoreCity or town.....Chase (If outside city or town limits, write RURAL and give nearest town)Street No.....Eastern Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.....unknown3. (b) Social Security Number
unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 16 19 46 at 5:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 29 19 46 to May 16 19 46and that I last saw him alive on May 16 19 46Immediate cause of death.....General Paresis
DURATION Known to us since 4/29/46

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other.....

Address.....Crownsville, Maryland Date signed 5/16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

04525

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Anne Arundel

City or town..... Dorsey

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:

Forest Ave & Dorsey Rd

How long in hospital or institution?

3. (a) FULL NAME

Edna Rachel Seibert

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

B. (b) Name of husband or wife..... Walter Strong Seibert

6. (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.)

Aug 21 - 1889

8. AGE: Years Months Days If less than one day

46 8 15 hrs. min.

9. Birthplace..... Elvry Balto. Md
(Town, county, and state)

10. Usual occupation..... Domestic

11. Industry or business..... Housewif

MOTHER FATHER 12. Name..... Albert F. & Mary Hamilton

13. Birthplace..... Berford Maryland

14. Maiden name..... Margaret Hammon

15. Birthplace..... Berford Maryland

Mrs. Walter T. Herbert

16. Informant.....

Address..... Forest Ave & Dorsey Rd

Burial 17. Date thereof..... 5/9/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Meadow Ridge Memorial Park

Location..... Howard Co., Md.

18. Funeral director..... WM. J. TICKNER & SONS

Address..... Balto., Md.

19. (Signature of registrar) 19. (Date signed) 20. (Signature of registrar) 21. (Date signed)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md

County..... Anne Arundel

City or town..... Dorsey

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Forest Ave & Dorsey Rd

(If rural, give LOCATION)

2.(a) If veteran, name war..... None

3. (b) Social Security Number

214-20-1435-

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 6 1946 at 10 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Feb 17 1946 to May 6 1946,

and that I last saw her alive on May 5 1946.

Immediate cause of death..... Heart attack

Cardiovascular

General circulatory

Duration 3 yrs

Due to..... Myocardial

Ectopic heart 2 mo

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?.....

23. SIGNATURE.....

M. D. or other.....

Address..... Elvry Balto. Md. Date signed 5/6/46

PLEASE, WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

P4526

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth Smallwood.

4. Sex

F

5. Color or race

W

6. (u) Single, married, widowed, or divorced

widowed.8. (b) Name of husband or NoneRubin Smallwood

7. Birth date of deceased (mo., day, yr.)

Nov. 19 - 1863

6. (c) If alive, give age

years

8. AGE:

Years
82Months
6Days
8

If less than one day

hrs.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Henry Ruth

MOTHER FATHER

12. Name Baltimore Md

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date reg'd by registrar)

Data thereof May 31-46

(month) (day) (year)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:
Anne Arundel
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
2½ years
Hospital, institution, or street address where death occurred:
District Training School
.....
How long in hospital or institution?.....
2½ years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....
District of Columbia
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No. 121 7th St. N.E.
(If rural, give LOCATION)

2.(a) Is veteran, name war.....

3. (a) FULL NAME Shirley Ann Smith

3. (b) Social Security Number

4. Sex f	5. Color or race W	6.(a) Single, married, widowed, or divorced S
-----------------	---------------------------	--

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) **7-30-38**
.....
8. (c) If alive, give age..... years

8. AGE: Years 7	Months 9	Days 24	It less than one day hrs. min.
------------------------	-----------------	----------------	---

District of Columbia
9. Birthplace.....
(Town, county, and state)

10. Usual occupation **inmate**

11. Industry or business

FATHER **Irvin Smith**
12. Name.....
13. Birthplace **D.C.**

MOTHER **Mary Clyde Warren**
14. Maiden name **D.C.**
15. Birthplace

16. Informant **records of District Training School**
Address **Laurel, Maryland**

17. **Burial** Date thereof **5-24-46**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Cedar Hill Cemetery**
Location **Hyattland Md.**

18. Funeral director **William F. Jones**
Address **300-4 St N.E. D.C.**

19. Date rec'd by registrar **May 24 1946**
(Date rec'd by registrar) **Registrar**

MEDICAL CERTIFICATION

May 24 46 at 7:50 p.m.

20. DATE OF DEATH.....
I CERTIFY that death occurred on the date above stated; that I attended deceased from11-12-43 to 5-24-46
and that I last saw her alive on 5-24-46Immediate cause of death **bronchopneumonia**
DURATION **1 day**

Due to.....

Due to.....

Other conditions **organic brain disease with mental deficiency and epilepsy**
(Include pregnancy within 3 months of death) **life**

Major findings of operations **none**

Date of op.

Autopsy results **none**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

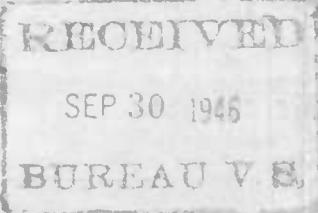
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE **Alan M. Drummond** M. D. or otherAddress **District Training School** Date signed **5-24-46**



~~PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.~~

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

04527

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel Co.
 County.....
 City or town..... Annapolis Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 64 years
 Hospital, Institution, or street address where death occurred: 93 Calvert St. Annapolis Md.
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel
 City or town..... Annapolis Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 93 Calvert St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... None

3. (a) FULL NAME

Walter Stevens

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced	
Male	Col.	Married	
B.(b) Name of husband or wife..... Mrs Effie Stevens			
7. Birth date of deceased (mo., day, yr.) May 3, 1882			
8. AGE: Years Months Days It less than one day			
64	64	48	hrs. min.
9. Birthplace..... Annapolis A. A. Co. Md.			
(Town, county, and state)			
10. Usual occupation..... Farmer			
11. Industry or business..... None			

MOTHER FATHER	12. Name..... Charles Stevens
	13. Birthplace..... Severn A. A. Co. Md.
MOTHER	14. Maiden name..... Martha Ann Lee
	15. Birthplace..... Annapolis Md.

16. Informant..... Mrs Effie Stevens
 Address 93 Calvert St. Annapolis Md.

17. Burial..... Date thereof..... 5 / 9 / 46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or columbarium..... Brew Hill Cemetery

Location..... West St. Extd. Annapolis Md.

18. Funeral director..... Mrs Chas. E. Hicks
 Address 45 Northwest St. Annapolis Md.

19. Date rec'd by registrar..... May 9, 1946
 (Date rec'd by registrar)

3. (b) Social Security Number
 214-05-0669

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5-5 1946 at 3 P.M.
 4-16 1946 to 5-5 1946
 and that I last saw h.m. alive on 5-4 1946

Immediate cause of death.....
 Lobar Pneumonia
 Cough

DURATION

Due to.....

Due to.....

Other conditions..... Sore throat & debility
 (Include pregnancy within 3 months of death)

Major findings or operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

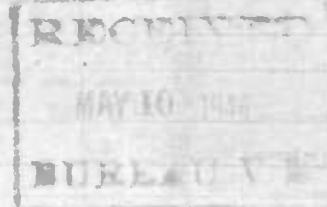
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... G. T. Allen M.D.
 M. D. or other.....
 Address 17 Conduit St. Date signed 5-7-46



04528

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

1. PLACE OF DEATH:
County Anne Arundel

City or town Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Regional Hospital, Ft. Geo. G. Meade, Md.

How long in hospital or institution? 3 Months and 2 Days

3. (a) FULL NAME

HERMANN STUHR

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife Liselotte Stuhr

7. Birth date of deceased (mo., day, yr.) February 2, 1910

8. AGE:	Years	Months	Days	If less than one day
	36	3	7	hrs. min.

9. Birthplace _____
(Town, county, and state)

10. Usual occupation Soldier, German Army (Cpl)

11. Industry or business _____

FATHER
12. Name _____
13. Birthplace _____

MOTHER
14. Maiden name _____
15. Birthplace _____

16. Informant U.S. Army Medical and Service Records

Address Ft. Geo. G. Meade, Maryland

17. Burial Date thereof 5/10/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or columbarium Post Cemetery

Location Ft. Geo. G. Meade, Md. (Anne Arundel)
Howard N. Blight Jr.

18. Funeral director Howard N. Blight, Jr.

Address 4914 Belair Road, Baltimore 6, Md.

19. 10 May 1946
(Date rec'd by registrar) *ALLAN G. BROTMAN, Lt., MC*

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Germany County _____

City or town Halle/Saale Saxonia Landrain
(If outside city or town limits, write RURAL and give nearest town)

Street No. 152 A Germany
(If rural, give LOCATION)

2.(a) If veteran, name German Soldier (Prisoner Of War)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 May 1946 1600 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 April 1946, to 9 May 1946, and that I last saw him alive on 9 May 1946.

Immediate cause of death Bronchopneumonia, cachexia and peripheral vascular collapse.
DURATION

Due to Carcinoma of stomach, generalized peritonitis secondary to gastrectomy on 26 April 1946.

Other conditions _____
(Include pregnancy within 8 months of death)

Major findings of operations 3 April 1946: Subtotal gastrectomy - (See other side) Date of op.

Autopsy results Confirmed as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *Jerry B. Gwin*
JERRY B. GWIN, CAPT., M.C. M.D. or other

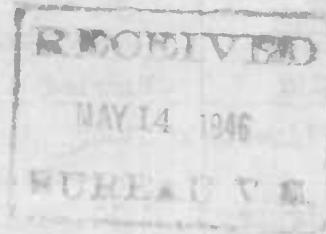
Address Reg. Hosp., Ft. Meade, Md. Date signed 10 May 46

VS A15

Findings of operations (continued): Carcinoma of stomach.

26 April 1946: Total gastrectomy - Carcinoma of stomach.

8 May, 1946: Generalized peritonitis found on laparotomy



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

162

04529.

28

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

Anne Arundel County

City or town Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 24 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 3 months, 24 days

3. (a) FULL NAME

SWANN - THEODORE

4. Sex

male

5. Color or race

black

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife Lydia Swann, Fairmount

Heights, Maryland

6.(c) If alive, give age unk. years

7. Birth date of deceased (mo., day, yr.)

1912

8. AGE:

Years
34Months
unknownDays
—If less than one day
— hrs. — mins.

9. Birthplace unknown

(Town, county, and state)

Trash Collector

10. Usual occupation

11. Industry or business

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Hospital Records

Address

Crownsville, Maryland

17. Burial Burial Date thereof 5/18/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory St. Lazarus

Location Chapel Point Md

18. Funeral director Hunt & Ryon

Address Waldorf, Md

19. May 16 1946 E7 Joyce Local

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Fairmount Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. unknown

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15

1946 at 3:50 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 21 1946 to May 15 1946

and that I last saw him alive on May 15 1946

Immediate cause of death

Fracture of skull

Fracture of both jaws

Fracture of right arm

General Paresis

DURATION

6 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide resident Date of 5/18/46

Where did injury occur? Crownsville, A.T., Maryland

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?), Crownsville State Hpt

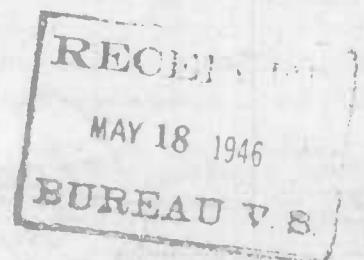
Means of injury fall from 2nd story Injured at work? no

Deputy

John M. Claffey M.D. Medical Examiner

M. D. or M. B. B. S.

Address Annapolis, Md. Date signed 5/18/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04539

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County.....

Anne Arundel Beach

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Elwood Taylor

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White married

6.(b) Name of husband or wife..... Hulda Taylor

7. Birth date of

deceased (mo., day, yr.)

February 2, 1874

6.(c) If alive, give age..... years

8. AGE:

Years Months Days If less than one day
72 2 29 hrs. min.

9. Birthplace.....

Kent County, Md.

(Town, county, and state)

10. Usual occupation.....

Farmer Retired

Retired

Unknown

Unknown

Unknown

Unknown

11. Industry or business

Unknown

12. Name.....

Hulda Taylor

13. Birthplace

Orchard Beach, Md.

14. Maiden name.....

Unknown

15. Birthplace

Unknown

16. Informant.....

Hulda Taylor

Address

Orchard Beach, Md.

17. Burial.....

Burial

Date thereof.....

0-3-46

(Burial, cremation, or removal. When?)

(month) (day) (year)

Cemetery or crematory.....

London Park

Location.....

Baltimore, Md.

18. Funeral director.....

George Schwab

Address

9101 Frederick Avenue

19. Date rec'd by registrar.....

5/2 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Cherry Hill Lane & East End Drive

(If rural, give LOCATION)

None

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 1, 1946 at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 1946

and that I last saw him alive on April 30, 1946

Immediate cause of death.....

Cardiac Arrest

Due to..... Hypertension

Chronic Endocarditis

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

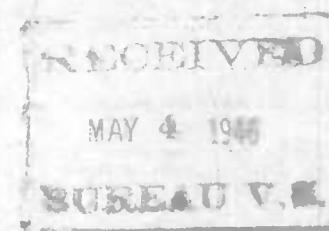
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... Dr. J. Alexander M. D. or other

Address..... 1000 B Avenue Date signed..... 5/3/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13d

04531

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

Anne Arundel

City or town Brooklyn Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 17 days -

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Widower

6.(b) Name of husband or wife Margaret Thompson
(nee Coppernall)

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1867

8. AGE: Years Months Days If less than one day
79 or 10 hrs. min.9. Birthplace Washington D. C.
(Town, county, and state)

10. Usual occupation Paper Cutter

11. Industry or business Printing Business

12. Name Robert Thompson

13. Birthplace New London, Conn.

14. Maiden name Don't know

15. Birthplace Wash., D. C.

16. Informant Mrs. Marie B. Trebee (Daughter)

Address 1429 S. Charles St., Balt., 30, Md.

17. Burial Data thereof May 22, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet Cem.

Location Baltimore, Md.

18. Funeral director J. Edward Evans

Address 1400 S. Charles St., Balt., 30, Md.

19. Date reg'd by registrar 5/20 1946 A. W. Hedrath
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Anne Arundel

City or town Brooklyn Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 102 - 11th Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1946 1946 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb-12 1946 to May 19 1946

and that I last saw him alive on May 18 1946

Immediate cause of death Myocarditis 3 mos.

Due to Arterio Sclerosis 6 mos.

Due to - Gastroenteritis 4 days

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

OB Whelton M. D. or other

Address 1279 Belmont St. Date signed 5/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

04532

Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County Anne Arundel

City or town Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Thirty-one days

How long in above place of death?

Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Annapolis, Maryland

How long in hospital or institution? Thirty-one days

3. (a) FULL NAME

Pasquale (n) TORANTINO

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife Flora Torantino (Wife)

7. Birth date of deceased (mo., day, yr.) January 6 1868
8. (c) If alive, give age 73 years

8. AGE:	Years 78	Mouths 3	Days 28	If less than one day hrs. mins.
---------	-------------	-------------	------------	---------------------------------------

9. Birthplace Italy
(Town, county, and state)

10. Usual occupation Ch. Musician Retired Inactive USN

11. Industry or business None

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. Flora Torantino (Wife)

Address 144 Prince George Street, Annapolis, Md.

17. Burial Date thereof May 8th 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Mary's Cemetery

Location Annapolis, Maryland

18. Funeral director John W. Taylor & Sons

Address Annapolis, Maryland

19. May 7 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. 144 Prince George Street, Annapolis, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (b) Social Security Number
Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4 1946 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-3 1946 to 5-4 1946

and that I last saw him alive on 5-4 1946

Immediate cause of death Cardiac Decom-

penstrophy

DURATION

Due to Atherosclerotic Heart Disease

Due to Atherosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

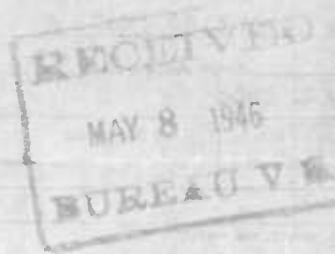
23. SIGNATURE Frank H. Thomas Jr. (ME) USN

M. D. or other

Address U.S.M.H. Annapolis, Md. Date signed 5-6-46

OPTION TO PURCHASE STATE CHARTER

NO ASK NO STAMPED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(B)*

04523

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel Co.

City or town Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Unknown

Hospital, institution, or street address where death occurred:

28 Calvert St. Annapolis Md.

How long in hospital or institution? ***

3. (a) FULL NAME

Nettie Watts

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Col. Married

6.(b) Name of husband or wife Joseph Watts

7. Birth date of deceased (mo., day, yr.) May 20, 1896 6.(c) If alive, give age 48 years

8. AGE: Years Months Days If less than one day
50 hrs. min.9. Birthplace Gaylesville A. A. Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

FATHER 12. Name John Edwards

13. Birthplace Millswamp A. A. Co.

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. Mary Johnson

Address 91 Shaw St. Annapolis Md.

17. Burial Date thereof 5/23/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brew Hill Cemetery

Location West St extd. Annapolis Md.

18. Funeral director Mrs. Chas. E. Hicks

Address 45 Northwest St. Annapolis Md.

19. May 23 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 28 Calvert St. Annapolis Md.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1946 at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16, 1946, to May 19, 1946, and that I last saw her alive on May 19, 1946.

Immediate cause of death

Acute myocarditis 4 days

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

R. L. Richardson
M. D.
Address Annafoft Md.
Date signed May 23 1946

RECEIVED
MAY 24 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04534

P

Reg. Dist. No.

24

1. PLACE OF DEATH:

County ANNE ARUNDEL

City or town RURAL - NEAR SEVERN

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

POST OFFICE - SEVERN, MD.

Stay in hospital or Inst. (yrs., or mos., or days) NONE

Stay in this community (yrs., or mos., or days) 16 YEARS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County ANNE ARUNDEL

City or town RURAL - NEAR SEVERN, MD.

Ward No.

Street No. 1 MILE FROM SEVERN

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

BERTHA ELIZABETH WEBER

3. (b) Social Security Number

216-10-4548

4. Sex FEMALE Color or race WHITE MARRIED

6 (b) Name of husband GEORGE B. WEBER

7. Birth date of deceased (mo., day, yr.) DECEMBER 21, 1896

8. AGE: Years 49 Months 4 Days 27 If less than one day hrs. min.

9. Birthplace HILLSBORO, QUEEN ANNE COUNTY

(Town, county, and state)

10. Usual occupation SEAMSTRESS

11. Industry or business CROWNSVILLE STATE HOSPITAL

12. Name JOHN BYARD

13. Birthplace QUEEN ANNE COUNTY, Md.

14. Maiden name SARA ELIZABETH GIBSON

15. Birthplace QUEEN ANNE COUNTY, Md.

16. Informant MR. GEORGE B. WEBER

Address P.O. SEVERN, MD.

17. Burial Date thereof May 21, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Woodlawn Cemetery

Location Woodlawn, Md.

18. Funeral director

Address 1003 W. Baltimore St.

19. (Date rec'd by registrar) 5/20/46

19. (Date rec'd by registrar) 5/20/46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 18

1946, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
17 MAY 1846 to 18 MAY 1946, and that I last saw her alive on 17 MAY 1946.

Immediate cause of death RESPIRATORY FAILURE

DURATION

Mrs. due to CEREBRAL HEMORRHAGE

Due to HYPERTENSION

Other conditions RIGHT HEMIPLEGIA AND
RIGHT VERTICAL STRABISMUS ONSET
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____

Injured at work? _____

23. SIGNATURE

Henry F. Zangara, M.D.

M. D. or other

Address 401 W. Annapolis Blvd Date signed May 18, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 303

04535

28

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Anne Arundel County
 County.....
 Crownsville, Maryland
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Harford

City or town..... Aberdeen (If outside city or town limits, write RURAL and give nearest town)

Street No..... unknown

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

WEBSTER - SADIE STANSBURY

4. Sex female	5. Color or race black	6.(a) Single, married, widowed, or divorced widow
------------------	---------------------------	--

8.(b) Name of husband or wife.....

8.(c) If alive, give age..... years

7. Birth date of
deceased (mo., day, yr.) 1876

8. AGE: Years 70	Months unknown	Days ---	If less than one day --- hrs. --- min.
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9. Birthplace..... Maryland
(Town, county, and state)

10. Usual occupation..... Housework

11. Industry or business

12. Name..... unknown

13. Birthplace..... unknown

14. Maiden name..... unknown

15. Birthplace..... unknown

16. Informant..... Hospital Records

Address..... Crownsville, Maryland

17. Buried..... Date thereof..... May 31, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Union M. E.

Location..... Aberdeen, Maryland

18. Funeral director..... Henry Tarring & Sons

Address..... Aberdeen, Maryland

19. Date rec'd by registrar..... May 28, 1946

Registrar..... E. T. Joyce

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 28

19. 46, at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 15 19. 46 to May 28 19. 46

and that I last saw her alive on May 28

19. 46

Immediate cause of death

General Arteriosclerosis

Known to us since 5/15/46

Due to

Due to

Other conditions Psychosis with Cerebral

Arteriosclerosis - Syphilis

Known to us since 5/15/46

(Include pregnancy within 3 months of death)

Major findings of operation

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

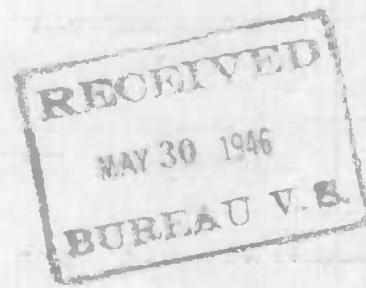
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

M. D. or other

Address..... Crownsville, Maryland Date signed 5/28/46



AGE: Balto. City birth cer.
Inf: funeral director in
person. - 5-6-46 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04536

Reg. Dist. No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

Anne Arundel County
Crownsville, Maryland

City or town. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 7 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 2 months, 7 days

3. (a) FULL NAME

WILLIAMS - JOHN

4. Sex

male

5. Color or race

black

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

ROSE ~~Williams~~ Nellie Williams, 1025 Cloney
St., Balto., Md.

6.(c) If alive, give age unk. years

7. Birth date of

deceased (mo. day. y.)

1905/12 Dec. 21 1908

8. AGE:

Years

37

Months

11

Days

Unknown

If less than one day

hrs.

min.

9. Birthplace

Baltimore City Md. (Town, county, and state)

10. Usual occupation

Coal trucking

11. Industry or business

John A. WILLIAMS

12. Name

Unknown

MD.

13. Birthplace

Unknown

MD.

14. Maiden name

Sarah

SUMMERFIELD

15. Birthplace

Unknown

MD.

16. Informant

hospital Records

Crownsville, Maryland

Address

Burial

Date thereof

May 7, 1946

(Burial, cremation, or removal, if any)

(month) (day) (year)

Cemetery or crematory

Mt. Olivet Cem.

Location

Mrs. Katie R. Williams

18. Funeral director

322 N. Schaefer St

Address

5/6/46

Dec. 1946

(Date rec'd by Registrar)

Registrar

Signature

M. D. or other

Address

Crownsville, Maryland

Date signed

5/2/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State

Baltimore City

City or town

(If outside city or town limits, write RURAL and give nearest town)

1025 Cloney Street

Street No.

(If rural, give LOCATION)

unknown

2.(a) If veteran, name war

3. (b) Social Security Number

unknown

MEDICAL CERTIFICATION

May 2

20. DATE OF DEATH

February 25 1946 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

in to May 2 1946, to May 2 1946

and that I last saw him alive on May 2 1946

Immediate cause of death

General Paresis

Known to us since

2/25/46

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

3. SIGNATURE

M. D. or other

Address

Crownsville, Maryland

Date signed

5/2/46

9697

Williams - John
Baltimore City
Admitted - February 25, 1946

Died - May 2, 1946

MAY 8 1946

BUREAU V